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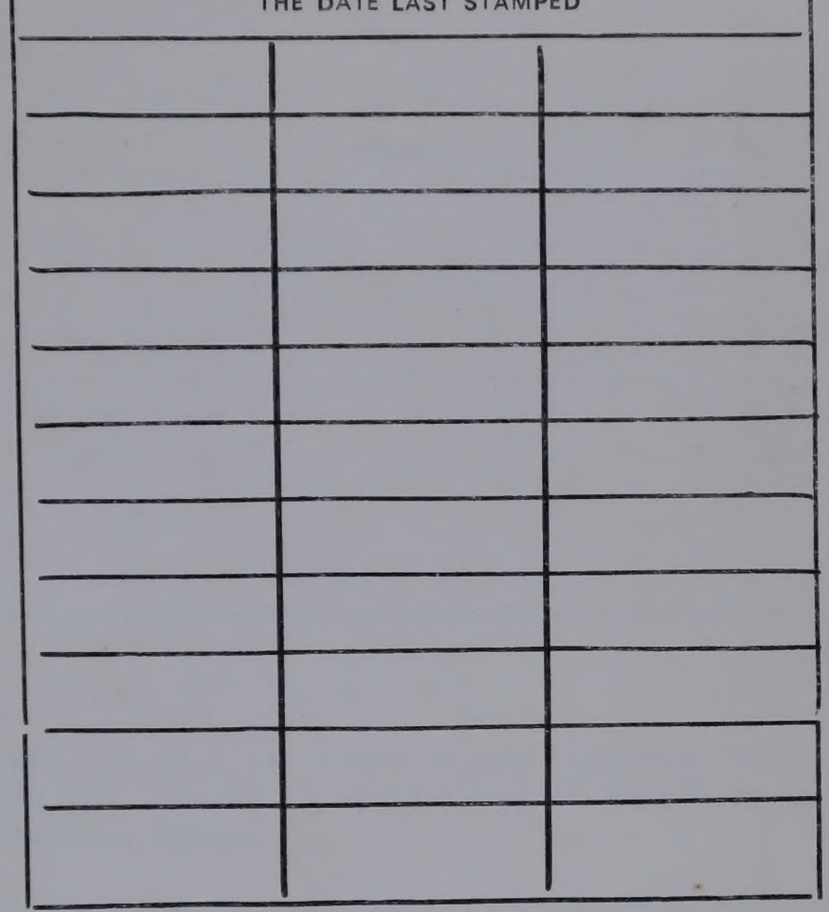
Working as Equals - Towards a Community-Based Evaluation System

Maureen Pagaduan
and Elmer M. Ferrer



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Working as Equals—Towards a Community-Based Evaluation System

Maureen Pagaduan and Elmer M. Ferrer

Introduction

Health problems are no longer the monopoly of health professionals. During recent years, social scientists and social workers have added health to their list of concerns in recognition of the fact that health problems stem largely from those of poverty. Medication, for example, may solve the immediate needs of patients, but in the long run it may not prevent disease, nor enable the patients to acquire the necessary medical services they need.

It is recognized that the process of eliminating poverty is a long-term proposition. However, this process is both a social and political act, social because it involves classes of people and the resolution of conflicts that ensue from their clash of basic interests, and political because it entails the utilization and harnessing of power by people to bring about the social restructuring needed.

Leyte's health programme in the Philippines is an attempt to see health problems in this perspective. Appropriately termed *Makapawa* (meaning "to enlighten"), it sees the problem not as a phenomenon isolated from other social illnesses but as a symptom of an unhealthy society. The programme also recognizes the crucial role of the people in the struggle for change, and encourages their participation not only in the solution of health problems but also in decision-making involving other critical issues which are of social and political significance.

In 1979 *Makapawa's* initiators, the Rural Missionaries of the Philippines, saw the need to re-evaluate the programme on its own terms. The idea of commissioning a research team recognized as "experts" in the field of evaluation was rejected on the grounds that such a team might assess the programme's growth according to the team's own standards which might be out of context with the programme's own philosophy. What was sought was an evaluation characterized by people-oriented research. The participatory evaluation method employed in the *Makapawa* programme was a "Community-Based Evaluation System." (CBES).

The General Health Situation

A journal published in 1981 by the Inter-agency Committee for Primary Health Care in the Philippines pointed out that 15 million Filipinos belong to families with incomes of less than P3,000 a year.* According to the Asian Development Bank, Filipinos have the lowest food intake in Asia, 62 out of 100 Filipinos die without any medical attention, and of the 70% Filipinos who live in the rural areas, only 10% benefit from the services of medical doctors. Yet the Philippines is the world's largest exporter of nurses and second largest exporter of doctors; 46% of all hospital beds are concentrated in Manila where only 12% of the population reside; in Metro Manila there is one hospital bed

*Exchange Rate Philippine Pesos 8.92 to one US dollar in 1982.

for every 219 Filipinos, while in the provinces there is one bed for every 1,013 people; there is one doctor for every 700 Filipinos in the cities, whereas in the towns there is a doctor for every 5,000 residents; 880 towns lack health centres; in one province (Mindanao) there is only one public health physician for 38,520 people; and 80% of Filipino children suffer from malnutrition. The situation described above characterized the area in which the *Makapawa* programme was set in 1976.

Location and Origin of the Makapawa Programme

Leyte is one of the islands in the Visayas region south of Manila. In 1976, the island had a total population of 1,200,000. 78% of these resided in rural areas. Two-thirds of the population earned their living from farming, fishing and cutting logs. Two per cent could be called professionals and technical workers. Surveys by government agencies revealed that close to 60% of the population earned about P1,900 or less annually. Some 30% made about P2,000 to P4,000 with the rest having an income of P15,000 annually. Tacloban City, the island's northern capital enjoyed prosperous trade and commerce, a busy port, several higher institutions of learning, a university and an airport with daily flights to Manila.

However, a closer look at the health situation of the city revealed that something was amiss. In 1976, the leading causes of morbidity were pneumonia, gastro-enteritis, intestinal parasitism, malnutrition and tuberculosis, and of mortality, pneumonia, bronchitis, tuberculosis, malnutrition and gastro-enteritis.

Safe piped water facilities were available only to those who could afford them. About 33% of the population got their water supply from deep wells, public faucets, rivers and springs—regardless of pollution factors. Of the 150 doctors in Leyte, 60 were said to be in the capital and 43 in hospitals. The rest had their private clinics which catered to the richer segments of the population. According to surveys, there was at that time one doctor to every 12,000 people in the province. As for doctors assigned to public health clinics, there was one to every 33,000 residents in Tacolban.

Prior to 1976 St. Paul's Hospital had organized its own health programme. As early as 1965, the hospital had had a mobile and several static clinics which offered medical services free or at reduced fees. But these came to an abrupt end with the recognition that their services had failed to change the general health situation. What was realized instead was that society's health problems could be traced to its economic illnesses, and to the political structures which enabled economic interests and small elite groups to maintain their stranglehold on power.

It is the economic system which provides the structure for power held by particular social groups or classes by propagating class ideologies and class organizations, which in turn impose a collective class will. This class therefore gains the upper-hand in virtually all decision-making processes, and in effect renders the other classes powerless. Any attempt to fundamentally alter the patterns of inequality in health thus required the total restructuring of the economic, political and cultural aspects of the health care delivery systems.

Objectives and Organization of the Programme

The Makapawa programme defined four general objectives: (a) to create an

awareness of the structures that hinder human development; (b) to bring about organized community action; (c) to inculcate self-reliance to bring about the maximum utilization of existing resources; and (d) to increase popular participation in decision-making processes.

Initially, out of 51 towns and some thousand *baranguays*, (villages) 10 *baranguays* from four different towns and a slum district in the city were chosen as pilot areas for the programme. Trainees were selected to be community health workers (CHWs) on the basis of personal leadership abilities and their interest and willingness to serve their particular communities. They were asked to conduct preliminary surveys of their communities prior to their training, the results of which would provide them with some baseline data for the first training period.

The programme's backbone was provided by a full-time staff of six community organizers (COs) and one nurse. The training was residential and emphasized lectures, discussions and field trips. Topics discussed were: Good Health, Nutrition, Environmental Sanitation, Family Life and Responsible Parenthood, Maternal and Child Care, Mental Health, First Aid, Dispensation of Medicines, Reporting and Record-Keeping. Field trips included visits to the Rural Health Units, the Schistomiasis Control and Research Center, the Philippine Tuberculosis Society Clinic and Hospital and other government hospitals.

After that, the CHWs were required to share their knowledge with their respective communities, activate the communities to avail themselves of the services offered by rural health units, encourage people to improve their environment, and provide first aid and referral opportunities. The CHWs conducted regular meetings to discuss health concerns and economic issues and activities —like pig-dispersal programmes, copra production, irrigation problems, usury, unemployment and low agricultural wages. General meetings of CHWs were held monthly to assess problems and accomplishments. Four years later in 1979, an activity described by the programme initiators as a "major leap forward" was started. It involved the training of local community organizers—a major feat considering that the existing COs were college graduates and professional social workers.

At this time, those involved in the programme saw the need to learn from the rich experiences of *Makapawa*. An evaluation of the programme was considered timely and relevant.

The Search for an Appropriate Evaluation Process

The idea for a project to develop a Community-Based Evaluation System first surfaced during an orientation workshop on Community-Based Health Programmes in July 1978. This was attended by programme practitioners, medical doctors, interns and students, and some professors of social work and community development from the University of the Philippines. Discussions highlighted the fact that so much experience had accumulated in the practice of such programmes throughout the country that it was time to evaluate their effectiveness and relevance to the needs of the people. Moreover, it was pointed out that an appropriate evaluation system must provide for active participation of the community.

A further meeting and more consultations stressed the importance of the evaluation process itself. Rather than seeking a process applicable to a single programme it was pointed out that if the correct process of evaluation could be discovered, then it would be possible to apply this to other programmes.

The dominant evaluation and research methods traditionally used in the Philippines are versions of the American and European model which attach importance above all to: (1) constructing instruments that measure changes with statistical precision and replicability and, (2) academic objectivity. The methodology of conventional social science research emphasizes the aggregation of statistics, the designing of measuring instruments in offices isolated from real life situations, and the interpretation of data by persons not familiar with the community or people concerned. It is largely unable to obtain the perceptions or experiences of the people involved in the development programme being studied. More critically, dominant social science research rests on an object-subject separation that gives rise to inequality between researchers and people and further still to a relationship wherein the researchers dominate the research process. It dwells on the object-subject separation rather than on the separation and unity of equal persons, a subject-subject relationship. Thus, dominant social science research is unable to enable subjects of research to develop their full human potentials and in this sense is anti-developmental.

In keeping with the community-based character of the programme, what was needed, it was recognized, was a method that would not so much elicit answers and arrive at a greater understanding of the subject by the investigator, but one which would provoke people into asking more questions and obtaining a better understanding of their own socio-economic conditions. Such a method would thereby raise their collective level of consciousness and unleash the impetus towards more massive and organized developmental activities.

This method, which has been called "participatory" research, involves the full and active participation of the community in the entire process. The subject of the research originates in the community itself, and the problem is defined, analyzed and solved by the community. In that the participation of the community in the process facilitates a more accurate and authentic analysis of social reality it can be said to be a more scientific method of research. The researcher is a committed participant and learner in the research process, a militant rather than a detached observer.

The whole approach enables and encourages the researchers to enter into a relationship with the people on the same level, inviting them to share their views and experiences while sharing their own. While two such views may greatly vary, depending upon each others' sphere of activities and orientation, the setting is then potentially open for the learning process on both sides.

A Phased Evaluation Scheme

The Community-Based Evaluation System (CBES) involved four phases, with two steps in each phase. Dialogue with the participants was emphasized, with the role of the researchers being that of facilitators and co-investigators. Each of the four phases began with a workshop and ended with an analysis by the facilitators of the previous activities.

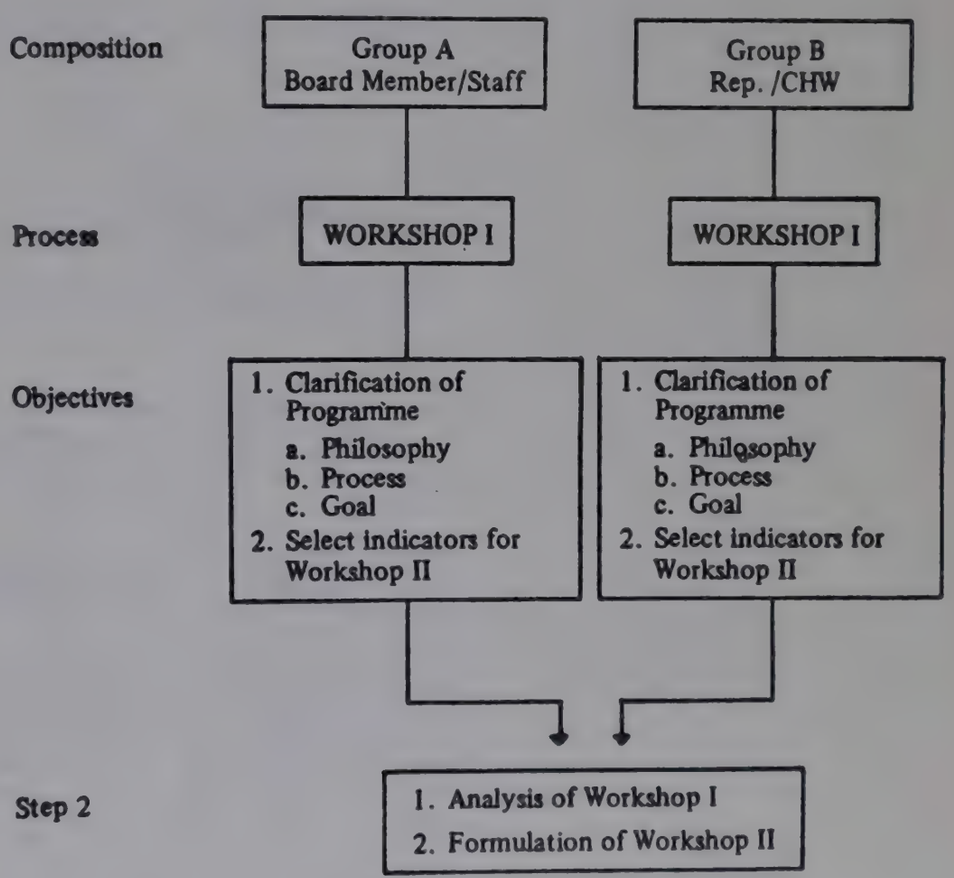
Phase I evoked from the *Makapawa* Board Members, staff and the community representatives each one's perception of the programme's philosophy, process and goals. Significant similarities or differences were noted on each level which could contribute to an analysis and evaluation of the programme.

Phases II and III were spent on closer dialogue with the people, the facilitators integrating with the community representatives and exchanging views with them regarding evaluation. Here they sought the assistance of the people in investigating the significant changes brought about by the programme, and its

effects on themselves, their families and communities.

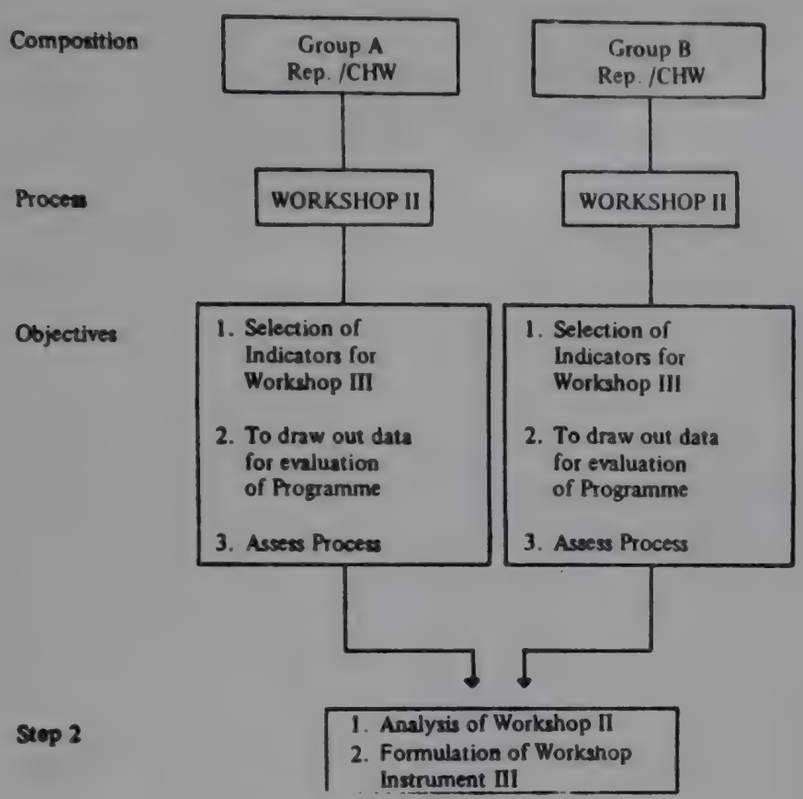
In *Phase IV* the facilitators collated and presented all the data, observations and experiences accumulated from previous phases by providing the initial framework for collation and analysis. This assisted in the setting of appropriate goals, in benefitting from past experience, and in being enabled to maximize future gains. The following diagrams illustrate the process described.

THE COMMUNITY-BASED EVALUATION SYSTEM (CBES)
PROCESS AND OBJECTIVES
PHASE I: *Perceptions of MAKAPAWA'S Philosophy, Process and Goals*



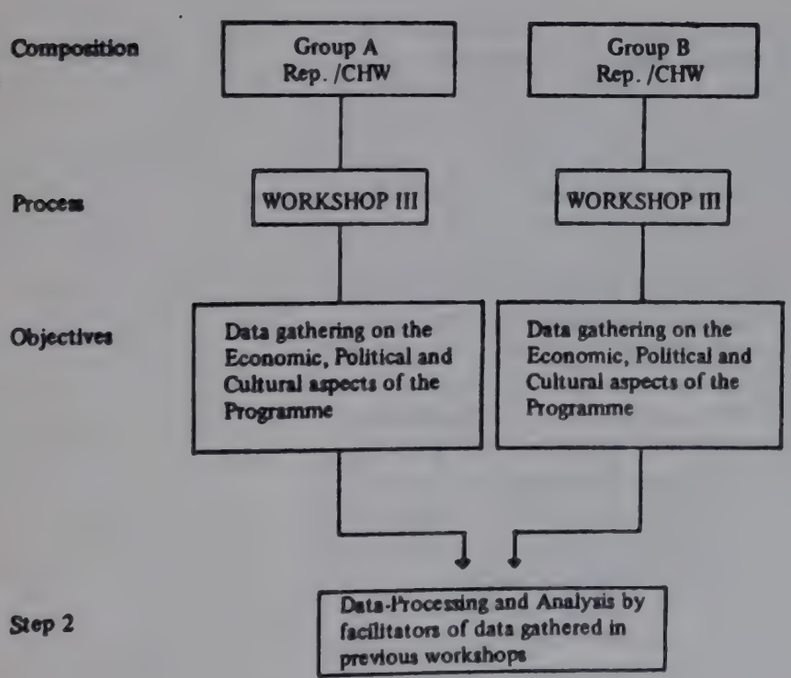
PHASE II: *A Dialogue with the Community*

Step 1



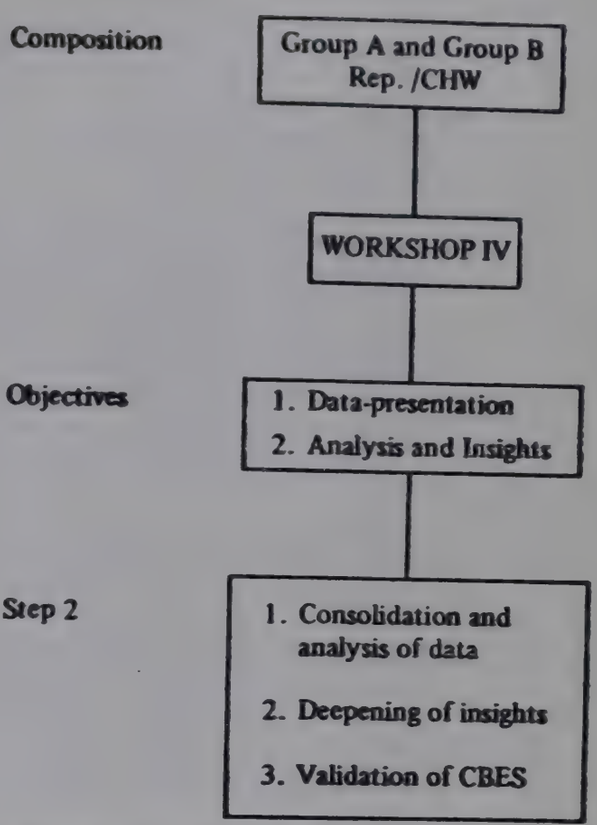
PHASE III: *Assessing Community Impact of the Programme*

Step 1



PHASE IV: ***Data Presentation, Analysis and Synthesis***

Step 1



In the first phase the workshop was attended by twelve participants consisting of the programme staff, two board members and community organizers. The facilitators kept the atmosphere informal, emphasizing that it was a "congregation of friends who came to share common experiences" and that the facilitators were not "experts" who enjoyed a monopoly of ideas. In this atmosphere the objective was accomplished of arriving at a common identification of what was to be done, the roles to be played, expectations to be met and the importance of the activity. The sharing was encouraged of experiences relating to family background, occupation and reasons for attending the meeting.

There was a brief presentation of the reasons for wanting to evaluate the *Makapawa* programme and then clarification of the meaning and objectives of evaluation in general. Evaluation was defined as the assessment of progress in relation to the programme's philosophy and goals with the addition of increasing the participants' understanding of their own experiences through systematic collective self-assessment. They were therefore expected to improve the practice of, and commitment to, the tasks they had set themselves to accomplish, to derive constructive lessons from their experiences, and finally to be more motivated in their collective action to promote their objectives.

Workshop objectives were defined as: clarification of the programme's philosophy and goals and selection of indicators for the evaluation instrument. Direct questions were posed to participants in order to learn how they understood the programme's philosophy, process and goals. For example, these questions

were asked: What is *Makapawa*? For whom is it? Where is there a need for it? In what aspect of life is it most felt? Reports were prepared of the work in two groups.

Diversity in perception

For such a small group to express diverse perceptions of the programme's philosophy, process and goals was understandable due to their varied backgrounds. Those directly engaged in organizing felt more the concrete needs of the people and saw the programme's value in relation to those needs. A few others expressed an abstract understanding of the programme, noting its "developmental" and "humanistic" role in society.

While there was a uniformity in the understanding of the programme's process, again there were differences of views as to its goals. The first group categorized the programme's goals into short-term and long-term ones. The latter were further subdivided into economic, political and cultural goals. The first group envisioned no less than a thoroughgoing change in society's economic, political and cultural structures. It stressed "land reform and national industrialization" for its economic goal, "building a self-governing community with decentralized powers, and infusing a liberating and critical consciousness" in politics and culture respectively.

The second group expressed more short-term goals, like "the training of CHWs, the use of herbal and traditional medicines, and the setting up of income-generating projects and cooperatives." This group did not share the long-term views of the former group.

An assessment of the workshop pointed out several positive effects: the questions asked were seen to be clear and holistic. They followed a correct sequence, reviewed past activities in the proper light and were generally educative. The process likewise enabled everybody to express his/her views, check and clarify each other's recollection of facts and events, and to be thorough and systematic.

Community Involvement in the Evaluation Process

While the previous workshop was held in a hospital setting, the workshop with the community took place in a barrio chapel, a five-by-ten metre cement and wood structure, with two long wooden benches and a regular-size blackboard.

This was the critical evaluation phase because at this point it could be seen how far or how deep the community residents had grasped the programme's philosophy, process and goals. While the staff and board members were able to be more articulate in their views and feelings, the community participants were less privileged in this sense. Most of the latter had not gone through higher education. The majority were housewives aged between 20 and 53 whose husbands were carpenters, drivers, storekeepers or jobless, and whose incomes ranged between P100 and P300 a month.

The conduct of the workshop was similar to the previous one, and practically the same questions were posed. Only the framing differed. The guideline questions for the staff were of a conceptual type, while those of the latter tended to be more experiential. The questions were also divided into two sets relating to the programme and its evaluation. The questions included the following: Since the start of the programme, what changes did it bring to you? In what aspect of your life is the programme most and least felt? What do you

think are the problems of your community and your country? Do you think there is a need to evaluate the programme? Why?

The community participants' views were found to differ widely from those of the staff. According to the community representatives the programme enabled them to solve community problems and acquire more knowledge. Its effects were most felt in areas of health concerns, in developing local leaders, and as it affected individual iniatives. *Makapawa's* bigger role, however, was hardly perceived. They said the programme did not enable the majority to participate in major decision-making processes. It was likewise considered ineffective in the face of other problems like unemployment, poverty, high prices and low wages. However, the programme's pro-people orientation was clearly seen.

The community's perception of the country's problems was also felt in more concrete terms. The problems included unemployment, low wages, widespread poverty and disease, corruption in the government bureaucracy and high taxation. Some groups even singled out foreign business as the major cause behind the country's social and economic problems, and both of the latter were further worsened by "lack of education, unity and understanding among the people."

All of them agreed on the necessity for a thorough-going evaluation of the programme. "We must see the good and the bad that it has done so that we don't return to a situation of disunity and misunderstanding." "We want to know if there is any development, if there is something that has to be changed, to know the problems of the project in the community, and to find out what projects still need to be done."

When an assessment of the workshop was held afterwards, most of the participants agreed that the questions posed were adequate. "It reminded us of what we have done in the past and makes us proud of what we have accomplished." One question was singled out as being difficult to answer though: "In what aspect of life has *Makapawa* the most and the least effect?"

Using Dialogue to Select Indicators

The objective of the next workshop was to measure changes in the community in relation to the goals of the programme. Indicators had to be formulated with which community representatives could themselves evaluate the programme. The assistance of two experienced staff members was elicited. In the ensuing discussion it was agreed that the programme's activities had to be categorized into economic, political and cultural.

Activities veering towards some financial results—like hog-raising or preparation of herbal medicines—were considered "economic." Meetings, training sessions and measures for mobilization were classified as "political." Religious activities such as spiritual recollections and retreats were tagged as "cultural."

The measures selected were mainly quantitative. Indicators which emerged during discussion centred on savings, accessibility of health services and medicines, incidence of communicable diseases, people attending meetings, number of mobilizations undertaken, etc. These selected indicators were later presented to other staff members for further discussion and clarification.

Almost the same group of community representatives attended the second workshop. Instead of breaking up into small groups workshop II convened as one group. Participation of all was ensured by simply asking each one his/her ideas regarding the questions presented. The problem was discussed of how to

exactly measure the changes relating to the selected indicators, but a consensus was reached that methods should be kept as simple as possible. The significance of the programme was seen especially in areas of health, leadership formation and attitudes. For instance, the participants expressed great appreciation for the fact that *Makapawa* had been able to "decrease infant mortality rate," "lower medical expenses," and had "fostered a deeper sense of belongingness and camaraderie among community members."

Reaching a Consensus—The Third Workshop

The facilitators began the third workshop by summing up the results of Workshops I and II. The three categories of selected indicators were presented, economic, political and cultural. The objective of the workshop was therefore to gather data using the workshop instrument developed.

The first set of questions related to data sought regarding the health problems of the people: "What was the most frequent illness of people in the barrio? What were the available services from government and private sectors? Who was usually approached by the people? Did the frequency of services increase, decrease or remain the same? How much was ordinarily spent on medicines, doctors and transportation in the past?"

The second set of questions related to "political" aspects of the programme. "How many members did the *Makapawa* have? How many were active in meetings and soliciting medicines? What were the strengths and weaknesses of *Makapawa's* leaders?"

The third set of questions concerned the religious activities which emerged as the most dominant form of cultural activity: "How many attended such sessions now and in the past? What did they learn from these? What ideas, customs and beliefs did these inculcate in the people?" As in the previous workshops, participants commented that the questions were fairly easy to answer, adding that evaluation of this type was helpful and should be done annually.

Towards an Awareness and Understanding of Realities

At the fourth workshop the staff, board members and community representatives were joined together in one setting. Of the 16 who attended, 10 were CHWs and representatives and the rest were from the staff and board. The objective of this workshop was to feed back the findings gathered from the three previous workshops and conduct with the people an initial review of the CBES process. This time the facilitators played a more dominant role by presenting their synthesis of the data and observations within a definite analytical framework.

As an opening statement visual aids were used to explain differences of views regarding the same programme. While some staff members and board saw it within the broad perspective of its initiators, community representatives and health workers simply viewed it as a health programme that tried to maximize community resources. On the basis of the data gathered, the programme had failed to inculcate a long-term vision, limiting the people's scope for understanding to felt needs such as poverty, unemployment, low wages and high taxes, and was not able to relate these to their structural causes. Even organized actions served only short-term ends, i.e., to meeting health needs, but had not

enabled them to recognize the potential power of an organized community.

Similarly, the question of self-reliance and people's participation has been appreciated only in so far as health is concerned. In some cases, it has brought about an increasing dependence of the people on the health workers and programme staff. Health workers have served as convenient "middlemen" between the community and church-related health institutions (e.g., St. Paul's Hospital).

These limitations in outlook were further reflected in the training of CHWs. Many of them still felt inadequate and had to encourage the people to go to established health institutions for their common illnesses. Because of the training they got, many such workers emerged as their village's new "elite."

After going through the data in the light of the programme's objectives, the evaluation process was examined. The active participation of the people in the three previous workshops was noted. According to some participants the process had one very positive effect. It erased ideas that evaluation and research was prohibitive and out of the reach of the masses. They could, all participants agreed, be "simple and uncomplicated."

Findings of the Evaluation of the MAKAPAWA Programme

Understanding of holistic approach to development

The *Makapawa* programme sought to bring about awareness of situations in which structures were preventing the attainment of basic human needs for many. To the staff, board and some CHWs, this holistic concept of development was clear. But to the majority of participants this did not appear to be so. From the data gathered it became evident that everybody expressed concern for the country's apparent illnesses, but most were unable to relate them to economic, political and cultural structures. They failed to see how an economic system determines social relationships, and how and why political structures enhance and strengthen the power of one class.

The programme expressed a kind of naiveté in its analysis of society. It tended to gloss over the presence of social classes delineated by differences in economic interests, and therefore in conflict with each other. It saw society as one homogenous body, basically free of such conflicts of interests. This view prevented them from distinguishing those who are for change and those against. This shortsightedness and fragmented understanding of the programme's approach to development thus led to populism and sporadic outbursts of activity. An increased perception of ill-health and other immediate problems did not lead towards a deeper understanding of the governing social, political and economic structures. Consequently, its efforts to find definitive solutions to problems had become stifled.

Participatory evaluation process fostered self-confidence and enhanced collective understanding of the situation

In the evaluation process the participants and staff learned from each other. The staff and other resource persons drew out ideas from the participants instead of dictating answers. The participants were taught to arrive at knowledge through precise observation and experimentation, derived therefore from their own experience.

Leadership development influenced by the quality of participation

During the participants' original training a "dialogical" approach had

resulted in training time, place, content, expectations and responsibilities being collectively discussed and decided upon. However, the general understanding of people's participation had remained populist in definition and interpretation. The programme has failed to synthesize and advance the people's perception of their problems and situation in a holistic way. This shortsighted vision had had the effect of stunting the leadership capabilities of the community. A strong leadership had not emerged from the ranks of the people. Their officers and CHWs did not even initiate plans and activities on their own.

The workshops—balance between participation and leadership

The dialectical character of participation in evaluation was not always fully grasped by the facilitators. In their efforts to maximize participation on the people's part, they often loosened their leadership and facilitating role in the workshops. In this way they failed to synthesize the ideas of the people and raise them to the level of theory which the people themselves could grasp.

Conclusions

Towards a maturity of vision

Although the *Makapawa* programme believed in the interrelatedness of the economic, political and cultural aspects of the health care delivery system with the larger social structures, it lacked a sufficiently deep understanding of such relationships to be able to promote a restructure of the social order. Consequently, programme efforts to find definitive solutions to problems had become trapped in short-sighted solutions to community health problems.

Though the *Makapawa* programme had identified its development philosophy, its definition of its role in the development process had not been given similar attention. For example, it was not clear what functions the CHWs would perform or how they would perform them in relation to restructuring of the social order. Their tasks of providing health services were not consciously related to their task to raise the people's consciousness. The programme had unconsciously developed the people's collective commitment to its philosophy and goals. However, normal assessments on programme strengths and weaknesses had also made room for liberalism to develop among the staff and community. Assessment sessions had become spontaneous outpourings of personal feelings and weaknesses that did not pinpoint the contribution of attitudes to work and responsibilities. Fruitful criticism and self-criticism sessions could not therefore be conducted when individualism was given full play.

People as subjects

In contrast to traditional research and evaluation processes, the Community Based Evaluation System affirms the possibility of working as equals with the people. It negates the dominant role of the professional researcher, or the programme policy-makers and staff defining problems and analyzing and interpreting the subjects of research. In addition the data collected from the participants were more accurate than if obtained by a random survey of respondents. Since most of the data were collected in groups, exaggerated responses were checked and avoided. According to the participants themselves, "the process allowed for everyone to express his/her views, check and clarify each other's recollection of events and processes, and to be thorough and systematic." The methodology also had a built-in simplicity. A method has been formulated by which change can be studied more quantitatively. The

words "increase," "decrease" and "the same" would have been allotted little significance had only numerical exactness been desired.

Towards a synthesis of theory and practice

The issues and insights that emerged in the course of undertaking the scientific and educational participatory evaluation approach raised questions and provided some answers, but were merely the start of efforts towards a greater synthesis of theory and practice. The causes of *Makapawa's* philosophical weaknesses and programme ineffectiveness and likewise those of the CBES approach, were pinpointed.

Partnership—a prerequisite

To be able to apply this methodology, to make research more participative, evocative and educative, the integration of the facilitators and researchers with the participants is of great importance. This refers not simply to physical integration, but rather to solid identification with the basic interests of the people. Without this sort of partisanship the essentials in the people's struggle for change cannot be fully grasped. What is needed is an ability to assess the people's knowledge and ways and feed them back at their own level of political awareness. For this to occur involvement with the people is required, in their work, problems, and way of life.

In practice, this means that more time should be allotted to carrying out a community-based-evaluation system with the people. It implies more than ever that development programmes must have a built-in evaluation scheme, possibly on a level-by-level basis, which involves organizers together with the people. Gradually such an evaluation process which is essentially an educative action-reflection-action process will supersede evaluations conducted by "intellectuals" alien to programmes. The educative role of such an evaluation approach is one of its major distinctions. A further characteristic is the immediate feedback of the results of the evaluation so that they can be of relevance to the programme. The discovery of a feedback system in a form not alien to the people but one that enhances their learning is rooted primarily in the integration process. Timing is also important. If, for example, the evaluation report comes too late, the library and not the people might be its final depository. Finally, the development of practical and empirical knowledge in this field requires the sharing of the results of new approaches to evaluation.

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